



Agency Name: _____

CLARITY HMIS: HUD-COC PROGRAM EXIT FORM

Use block letters for text and mark appropriate boxes with an "X". Complete a separate form for each household member.

PROGRAM EXIT DATE *[All Clients]*

		-			-				
Month			Day			Year			

CURRENT NAME *[All Clients]*

																		N/A
Last																		
First																		
Middle																		<input type="checkbox"/>
Suffix																		<input type="checkbox"/>

CONTACT INFORMATION *[Optional]*

Phone Number					-													
Email																		
Current Address (if applicable)																		
Street																		
City																		
State																	Zip Code	

HOUSING STATUS AT EXIT *[Head of Household and Adults]*

<input type="checkbox"/>	Homeless	<input type="checkbox"/>	Fleeing domestic violence	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	At imminent risk of losing housing	<input type="checkbox"/>	At-risk of homelessness	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Homeless only under other federal statutes	<input type="checkbox"/>	Stably housed	<input type="checkbox"/>	Data not collected

DESTINATION *[All Clients]*

<input type="checkbox"/>	Deceased	<input type="checkbox"/>	Rental by client, with VASH housing subsidy
<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter	<input type="checkbox"/>	Rental by client, with GPD TIP housing subsidy

<input type="checkbox"/>	voucher		
<input type="checkbox"/>	Foster care home or foster care group home		Rental by client, with other ongoing housing subsidy
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Residential project or halfway house with no homeless criteria
<input type="checkbox"/>	Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/>	Safe Haven
<input type="checkbox"/>	Jail, prison or juvenile detention facility	<input type="checkbox"/>	Staying or living with family, permanent tenure
<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Staying or living with family, temporary tenure (e.g. room, apartment or house)
<input type="checkbox"/>	Moved from one HOPWA funded project to HOPWA PH	<input type="checkbox"/>	Staying or living with friends, permanent tenure
<input type="checkbox"/>	Moved from one HOPWA funded project to HOPWA TH	<input type="checkbox"/>	Staying or living with friends, temporary tenure (e.g. room, apartment or house)
<input type="checkbox"/>	Owned by client, no ongoing housing subsidy	<input type="checkbox"/>	Substance abuse treatment facility or detox center
<input type="checkbox"/>	Owned by client, with ongoing housing subsidy	<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/>	Permanent housing for formerly homeless persons (such as: CoC project; or HUD legacy programs; or HOPWA PH)	<input type="checkbox"/>	Other
		<input type="checkbox"/>	No exit interview completed
<input type="checkbox"/>	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/airport or anywhere outside)	<input type="checkbox"/>	Client doesn't know
		<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Psychiatric hospital or other psychiatric facility	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	Rental by client, no ongoing housing subsidy	Specify "Other"	

IN PERMANENT HOUSING [RRH PROGRAMS ONLY - All Clients]

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
IF "YES" TO PERMANENT HOUSING			
Date of Move-In		___/___/_____	

HOUSING ASSESSMENT AT EXIT [HOMELESS PREVENTION ONLY - All Clients]

<input type="checkbox"/>	Able to maintain the housing they had at project entry	<input type="checkbox"/>	Client became homeless – moving to a shelter or other place unfit for human habitation
<input type="checkbox"/>	Moved to new housing unit		
<input type="checkbox"/>	Moved in with family/friends on a temporary basis	<input type="checkbox"/>	Client went to jail/prison
		<input type="checkbox"/>	Client died

<input type="checkbox"/>	Moved in with family/friends on a permanent basis	<input type="checkbox"/>	Client doesn't know
		<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Moved to a transitional or temporary housing facility or program	<input type="checkbox"/>	Data not collected

IF "ABLE TO MAINTAIN HOUSING AT PROJECT ENTRY" TO HOUSING ASSESSMENT

Subsidy Information

<input type="checkbox"/>	Without a subsidy	<input type="checkbox"/>	With an on-going subsidy acquired since project entry
<input type="checkbox"/>	With the subsidy they had at project entry	<input type="checkbox"/>	Only with financial assistance other than a subsidy

IF "MOVED TO NEW HOUSING UNIT" TO HOUSING ASSESSMENT

Subsidy Information

<input type="checkbox"/>	With on-going subsidy	<input type="checkbox"/>	Without an on-going subsidy
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DISABLING CONDITION [All Adults]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
		<input type="checkbox"/>	Data not collected

PHYSICAL DISABILITY [All Clients]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
		<input type="checkbox"/>	Data not collected

IF "YES" TO PHYSICAL DISABILITY – SPECIFY

Currently receiving services for physical disability	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know	
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused	
			<input type="checkbox"/>	Data not collected	
Long-term physical disability	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know	
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused	
			<input type="checkbox"/>	Data not collected	
Documentation of the disability and severity on file		<input type="checkbox"/>	No	<input type="checkbox"/>	Yes

DEVELOPMENTAL DISABILITY [All Clients]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
		<input type="checkbox"/>	Data not collected

IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY

Currently receiving services for developmental disability	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected

Expected to substantially impair independence	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected
Documentation of the disability and severity on file	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes

CHRONIC HEALTH CONDITION [All Clients]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused	
		<input type="checkbox"/>	Data not collected	
IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY				
Currently receiving services/treatment for this condition	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected
Long-term chronic health condition	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected
Documentation of the disability and severity on file	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes

HIV-AIDS [All Clients]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused	
		<input type="checkbox"/>	Data not collected	
IF "YES" TO HIV-AIDS – SPECIFY				
Currently receiving services/treatment for this condition	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected
Expected to substantially impair independence	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected
Documentation of the disability and severity on file	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes

MENTAL HEALTH PROBLEM [All Clients]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused	
		<input type="checkbox"/>	Data not collected	
IF "YES" TO MENTAL HEALTH PROBLEM – SPECIFY				
Currently receiving services/treatment for this condition	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected
Long-term mental health problem	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know

	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected
Documentation of the disability and severity on file	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes

SUBSTANCE ABUSE PROBLEM [All Clients]

<input type="checkbox"/>	No	<input type="checkbox"/>	Both alcohol and drug abuse	
<input type="checkbox"/>	Alcohol abuse	<input type="checkbox"/>	Client doesn't know	
		<input type="checkbox"/>	Client refused	
<input type="checkbox"/>	Drug abuse	<input type="checkbox"/>	Data not collected	
IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY				
Currently receiving services/treatment for this condition	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected
Long-term substance abuse problem	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected
Documentation of the disability and severity on file				
	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes

DOMESTIC VIOLENCE [Head of Household and Adults]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused	
		<input type="checkbox"/>	Data not collected	
IF "YES" TO DOMESTIC VIOLENCE				
Last Occurrence				
<input type="checkbox"/>	Within the past three months		<input type="checkbox"/>	One year ago or more
<input type="checkbox"/>	Three to six months ago (excluding six months exactly)		<input type="checkbox"/>	Client doesn't know
			<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Six months to one year ago (excluding one year exactly)		<input type="checkbox"/>	Data not collected
Are you currently fleeing?	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected

INCOME FROM ANY SOURCE [Head of Household and Adults]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused		
		<input type="checkbox"/>	Data not collected		
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY					
Income Source		Amount	Income Source		Amount
<input type="checkbox"/>	Earned Income		<input type="checkbox"/>	TANF (Temporary Assistance for Needy Families)	

<input type="checkbox"/>	Unemployment Insurance	<input type="checkbox"/>	General Assistance (GA)
<input type="checkbox"/>	Supplemental Security Income (SSI)	<input type="checkbox"/>	Retirement Income from Social Security
<input type="checkbox"/>	Social Security Disability Income (SSDI)	<input type="checkbox"/>	Pension or retirement income from former job
<input type="checkbox"/>	VA Service-Connected Disability Compensation	<input type="checkbox"/>	Child support
<input type="checkbox"/>	VA Non-Service Connected Disability Pension	<input type="checkbox"/>	Alimony and other spousal support
<input type="checkbox"/>	Private disability insurance	<input type="checkbox"/>	Other source
<input type="checkbox"/>	Worker's Compensation	Specify "Other"	
Total monthly amount:			

RECEIVING NON-CASH BENEFITS *[Head of Household and Adults]*

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
		<input type="checkbox"/>	Data not collected

IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY

<input type="checkbox"/>	SNAP	<input type="checkbox"/>	Other TANF Benefit
<input type="checkbox"/>	WIC	<input type="checkbox"/>	Section 8
<input type="checkbox"/>	TANF Childcare	<input type="checkbox"/>	Other Source
<input type="checkbox"/>	TANF Transportation	<input type="checkbox"/>	Temporary Rental Assistance

Specify "Other"

COVERED BY HEALTH INSURANCE *[All Clients]*

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
		<input type="checkbox"/>	Data not collected

IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS

<input type="checkbox"/>	MEDICAID (MassHealth)	<input type="checkbox"/>	Employer Provided
<input type="checkbox"/>	MEDICARE	<input type="checkbox"/>	Obtained through COBRA
<input type="checkbox"/>	SCHIP	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	VA Medical	<input type="checkbox"/>	State Health Insurance for Adults (ConnectorCare)